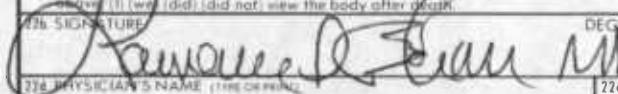


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it may be filed in the funeral director's office. Then please remove carbon from pages 1 and 2 and file within 72 hours after death. This certificate should be detached for use as the burial/transit permit. Then please remove carbon from pages 1 and 2 and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked **Yes**, show any injury, or other traumatic event. The medical examiner must be named at item 21.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8615373		
1 - STATE REGISTRAR			2a DATE OF DEATH 5 20 86							2b HOUR 1030 P.M.		
1. DECEASED NAME FIRST Albert MIDDLE O. LAST OGDEN BANSE			5. DATE OF BIRTH August 12, 1914			6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS			IF UNDER 1 YEAR MONTHS DAYS			
3. SEX Male RACE White			7. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's MD.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) residence,			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Copywriter(ret.)			12b. KIND OF BUSINESS OR INDUSTRY Advertising			
10. CITY OR TOWN OF DEATH Centreville Centreville			R.D. 1, Box 64H									
13a. STATE Maryland			13b. COUNTY QueenAnne's			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE R.D. 1, Box 64H, 21617			
14. FATHER'S NAME FIRST Albert MIDDLE Lewis LAST Banse			15. MOTHER'S MAIDEN NAME FIRST Julia MIDDLE Mae LAST Megronigle									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes (If Yes, give war or dates) WW II			16b. SOCIAL SECURITY NO. 154-18-8182			17. INFORMANT Brother ADDRESS R.D. 1, Box 64H Warren J. Banse, Centreville, Md. 21617			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-4 MO			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										BRAIN TUMOR		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE 												
22c. DEGREE MEDICAL STAFF ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>												
22d. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE May 24, 1986 23c. NAME OF CEMETERY OR CREMATORIAL Cross Keys Methodist Cemetery 23d. LOCATION CITY OR TOWN Cross Keys, Gloucester Co., N.J. COUNTY STATE												
24. FUNERAL DIRECTOR NAME Barton Funeral Home ADDRESS James H. Barton, Jr., Centreville, Md. 21617 25a. DATE REC'D. BY REGISTRAR MAY 26 1986 25b. REGISTRAR'S SIGNATURE 												

1

00-08503

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remember to file pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT! If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8615374		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20 DATE OF DEATH MONTH DAY YEAR			2b HOUR			
Roy Wrightson					BLUNT	May 25, 1986			6:10 P.M.			
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
Male		White		June 28, 1896		89 YRS.			IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH						
Maryland		USA				Queen Anne's						
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR HOME TRADE						
Centreville		Meridian Nursing Center/Corsica Hills		Carpenter(ret.)								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland										13c. COUNTY QueenAnne's	13d. CITY OR TOWN Centreville	13e. STREET ADDRESS / ZIP CODE 106 Windsor Ave., 21617
FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Mary			MIDDLE			LAST Melvin			
James Lawrence Richard Blunt												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Wife			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		221-09-4197		Mrs. Ava C. Blunt, Centreville, Md. 21617						3 yrs +		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										ascvd		
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 10</u> , 19 <u>86</u> , to <u>May 25</u> , 19 <u>86</u> say the deceased alive on <u>May 24</u> , 19 <u>86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										22b. SIGNATURE <i>J.R. Smith</i>		
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22d. ADDRESS John R. Smith, Jr., M.D. Centreville, Md. 21617										22e. DATE SIGNED 25/86		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial May 27, 1986		23c. NAME OF CEMETERY OR CREMATORIAL Chesterfield Cemetery		23d. LOCATION Centreville, Q. A. Co., Md.						
24. FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617		25a. DATE REC'D. BY REGISTRAR May 28, 1986		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Barton</i>								



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

5375

00-08049

1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR OF ESTI- MATED <input type="checkbox"/>	2b. HOUR MONTH DAY YEAR 2d HOUR
SEREVYATH			CHHAY			5-26-86 <sup>19</sup>	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	5-26-86 <sup>19</sup> 6:45a
Male	Asian	03-14-70	16 yrs.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County	
Cambodia		U.S.A.				MD.	
10. CITY OR TOWN OF DEATH Grasonville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 301-50 Southbound				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student	
13a. STATE Maryland	13b. COUNTY Q.A.	13c. CITY OR TOWN Chester	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P. O. Box 18	12b. KIND OF BUSINESS OR INDUSTRY 21619	
14. FATHER'S NAME FIRST Seang Iv Chhay		MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST Kim Se Hong		MIDDLE	LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <input type="checkbox"/> No		16b. SOCIAL SECURITY NO. 586-56-4080		17. INFORMANT Seang Iv Chhay		ADDRESS same as above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  8120 IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } (b) DUE TO, OR AS A CONSEQUENCE OF (c) }							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY 6:15A.M. 5-26-86 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of an auto/auto collision			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highwy.		21f. LOCATION STREET Rt. 301-50 Southbd		CITY OR TOWN Grasonville, Maryland	COUNTY Q.A.
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> TITLE (SPECIFY) ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> ASSISTANT MEDICAL EXAMINER							
DATE SIGNED 5-26-86							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-29-86	23c. NAME OF CEMETERY OR CREMATORIAL Stevensville Cemetery		23d. LOCATION CITY OR TOWN Stevensville	COUNTY Q.A.	STATE MD
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Chester, MD 21619		ADDRESS	25a. DATE REC'D. BY REGISTRAR MAY 29 1986		25b. REGISTRAR'S SIGNATURE		

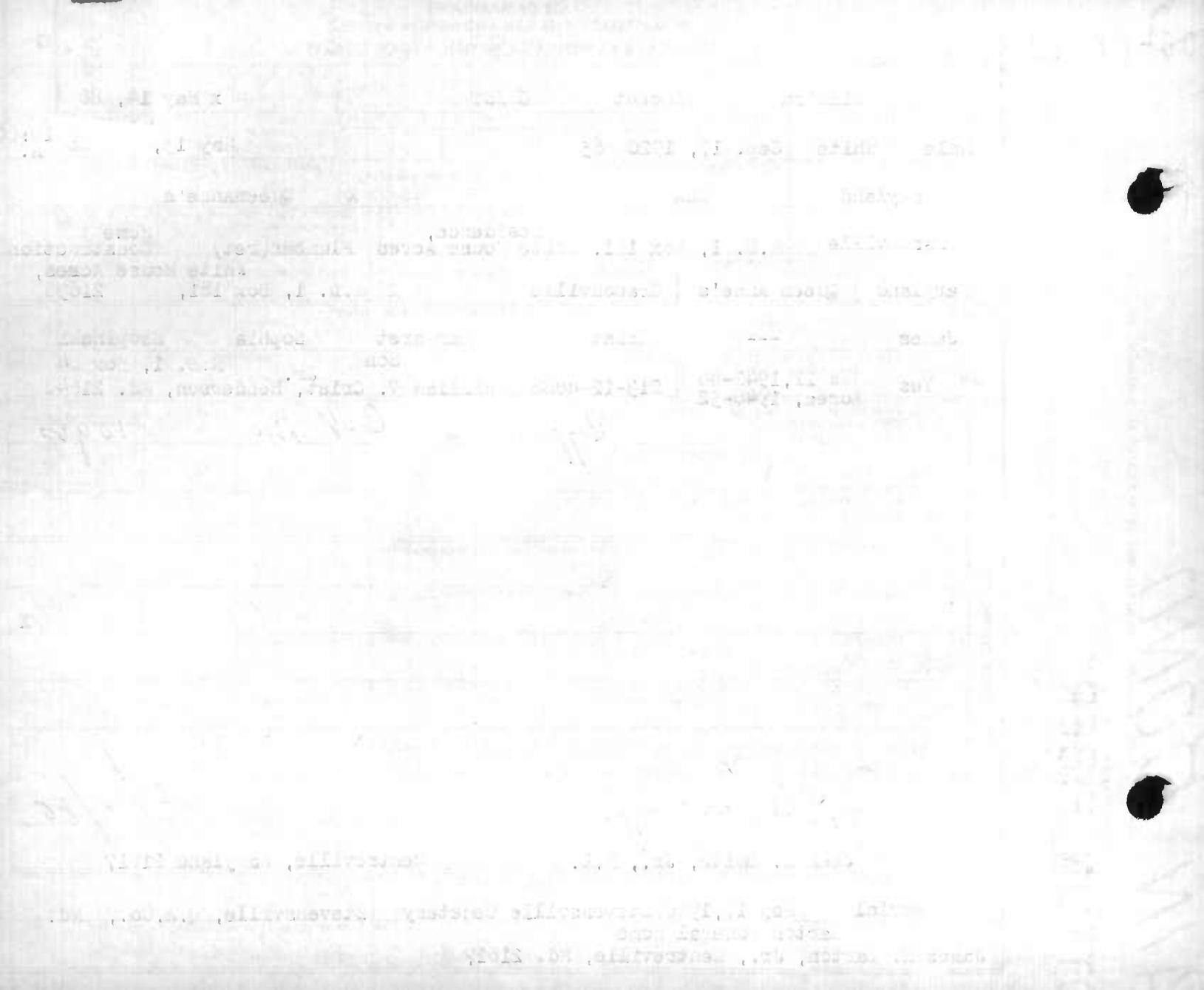
04000-0

(1)

00-07312

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. **AFTER DEATH:** WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 15376	
1- STATE REGISTRAR				2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED <input checked="" type="checkbox"/> May 14, 1986								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST					
William Vincent CRIST													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	
Male		White		Sep. 17, 1920		65 yrs.						May 15, 1986	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12d. KIND OF BUSINESS OR INDUSTRY			
Maryland		USA						Queen Anne's		Home Construction			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
Grasonville				R.D. 1, Box 181, White House Acres				residence Plumber(ret)					
13a. STATE Maryland				13b. COUNTY Queen Anne's		13c. CITY OR TOWN Grasonville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS R.D. 1, Box 181,		12b. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME FIRST James				MIDDLE ---		LAST Crist		15. MOTHER'S MAIDEN NAME FIRST Margaret		MIDDLE Sophia		LAST Skopinski	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES, NO, OR UNKNOWN <input checked="" type="checkbox"/> YES, ONE WAR SERVICE WW II, 1942-44 Yes Korea, 1948-52				16b. SOCIAL SECURITY NO. 213-12-4888				17. INFORMANT Son		ADDRESS Jr. R.D. 1, Box 84		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.				Hyperension C-V Dis									
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>J.R. Smith Jr.</i>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
TITLE (SPECIFY) M.D.												MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS								DATE SIGNED <i>5/10/86</i>	
John R. Smith, Jr., M.D.				Centreville, Maryland 21617									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL				23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial				May 17, 1986		Stevensville Cemetery				Stevensville, Q.A.C. Co.		Md.	
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Barton Funeral Home						May 20, 1986 <i>John Davidson Pendleton</i>							
James H. Barton, Jr., Centreville, Md. 21617													
BP													
DHMH - 17													
(VR A15 ME (5))													
20M 4/82													



**B** TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or interment.

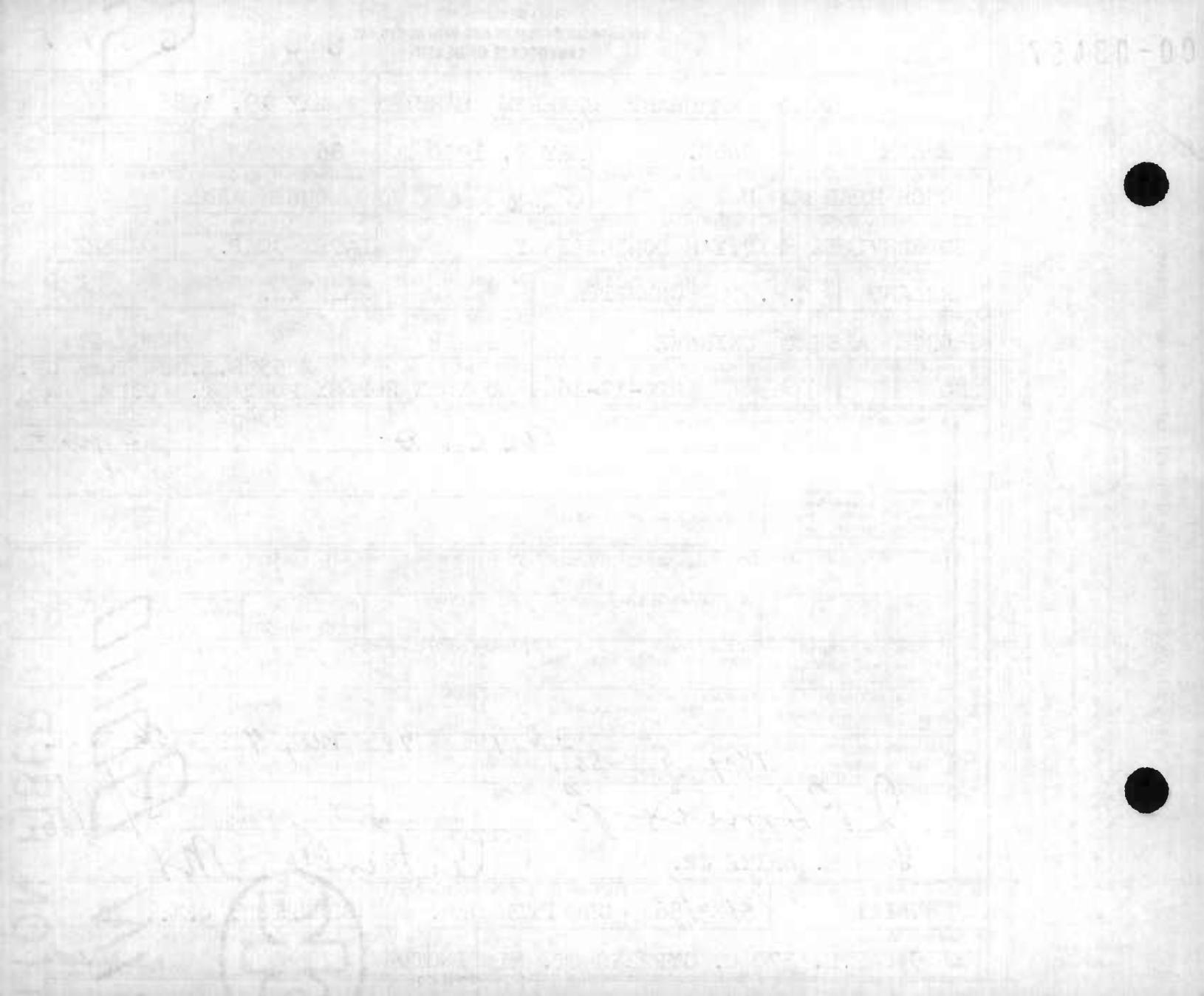
IMPORTANT: If death occurs at home, or if there is an injury or other unusual event, the medical examiner must be consulted.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8615377  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
ELLEN MERCHANT SKINNER HARTLEY				MAY 19, 1986					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
FEMALE		CAUC.		MONTH	DAY	YEAR	86	IF UNDER 24 HRS	
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH	
CHURCH HILL MD		USA						QUEEN ANNES	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
SUDLERSVILLE		KITTY'S DOMICILIARY		LATEX CORP.		CLERK			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		Q.A.		CRUMPTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		MAIN ST. 21628	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		MIDDLE		LAST
GEORGE		ALBERT	SKINNER		SUSIE				MERCHANT
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		2055 S.E. NEW YORK ST.		ADDRESS	
NO		220-12-1669		LUCILLE HOPELY		PORT ST.		LUCIE FLA	
<p><b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)  <b>PART I. DEATH WAS CAUSED BY:</b></p> <p>IMMEDIATE CAUSE (a) _____  DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last _____  (b) _____</p> <p>DUE TO, OR AS A CONSEQUENCE OF  (c) _____</p> <p><b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b></p>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1</u>, 19<u>78</u>, to <u>May 8</u>, 19<u>86</u>, that (I) (we) last saw the deceased alive on <u>May 10</u>, 19<u>86</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>									
22b. SIGNATURE <i>JR Smith Jr</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/1/86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		<i>Centrenille Md</i>					
JOHN R. SMITH JR.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		COUNTY STATE	
BURIAL		5/23/86		CRUMPTON CEM.		CRUMPTON, Q.A., MD			
24. FUNERAL DIRECTOR <i>Name</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
FELLOWS F.H. 370 W. CYPRESS ST. MILLINGTON				MAY 29 1986		<i>Rita Davidson-Pendleton</i>			

53400-00



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRAVEL PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 15378
1. DECEASED NAME (TYPE OR PRINT)				FIRST Bruce	MIDDLE Carlton	LAST Jones	2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/>	XX	MONTH MAY	DAY 19	YEAR 86	2b. HOUR 5-23
3. SEX <input checked="" type="checkbox"/>	4. RACE Male	5. DATE OF BIRTH MONTH 03 YEAR 1955	6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.	7. IF UNDER 1 YR. MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN 0	2c. DATE PRONOUNCED DEAD 5-23	MONTH MAY	DAY 19	YEAR 86	2d. HOUR 5:45 P.M.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Queen Anne's County, MD
10. CITY OR TOWN OF DEATH Church Hill				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 213 north of Church Hill Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cartographer - U.S. Gov't				12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland		13b. COUNTY Q.A.		13c. CITY OR TOWN Centreville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS Rt. 2 Box 331		21617		
14. FATHER'S NAME FIRST Harry Lee Jones				15. MOTHER'S MAIDEN NAME FIRST Nancy Lee Righter								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-66-7829				17. INFORMANT Nancy M. Jones				ADDRESS same as above
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: 8136 IMMEDIATE CAUSE (a) <u>Multiple Injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4:45XX 5-23 1986				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) bicyclist struck by truck				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road				21f. LOCATION STREET Rt. 213 north of Church Hill Rd., Queen CITY OR TOWN Anne's Co., Md. COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion												
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>				TITLE (SPECIFY) Assistant				DATE SIGNED 5-24-86				
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05-27-86		23c. NAME OF CEMETERY OR CREMATORIAL Highland Presbyterian		23d. LOCATION CITY OR TOWN Street		23e. COUNTY Harford		STATE MD		
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Church Hill, MD				25a. DATE REC'D. BY REGISTRAR 21623				25b. REGISTRAR'S SIGNATURE <i>MAY 29 1986</i>				
(VR A15 ME (5))												

100000 -

1000000 -

10000000 -

100000000 -

1000000000 -

10000000000 -

100000000000 -

1000000000000 -

10000000000000 -

100000000000000 -

1000000000000000 -

10000000000000000 -

100000000000000000 -

1000000000000000000 -

10000000000000000000 -

100000000000000000000 -

1000000000000000000000 -



0-08501

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

86 15379

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (THE OR PEPPEL)			FIRST <b>Mabel</b>	MIDDLE <b>Kirby</b>	LAST	2a. DATE OF DEATH	MONTH 05/24/86	DAY	YEAR	2b. HOUR 12:15 M			
3. SEX <b>Female</b>		4. RACE <b>White</b>	5. DATE OF BIRTH MONTH 04 DAY 16 YEAR 1901			6. AGE (IN YEARS LAST BIRTHDAY) 85		7. IF UNDER 1 YEAR MONTHS YRS.		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE COUNTRY <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Queen Anne</b>					
10. CITY OR TOWN OF DEATH <b>Centreville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Corsica Hills</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary Insurance</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Co.</b>					
13. USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION 13a. STATE <b>MD</b>		13b. DATE RESIDENCE BEFORE ADMISSION 13c. COUNTY <b>Kent</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RFD # 3 21620					
14. FATHER'S NAME FIRST <b>Robert</b>		MIDDLE <b>Lee</b>	LAST <b>Kirby</b>	15. MOTHER'S MAIDEN NAME <b>Ida</b>							<b>NEAL</b>		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>136 01 9321</b>			17. INFORMANT <b>Nursing Home Records Centreville, Md</b>			ADDRESS					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>QSCVA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. (b): DUE TO, OR AS A CONSEQUENCE OF (c):													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (d)													
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			19d. AUTOPSY?		19e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER) <b>AT HOME</b> <input type="checkbox"/> <b>NOT AT HOME</b> <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
		21d. INJURY OCCURRED <b>AT HOME</b> <input type="checkbox"/> <b>NOT AT HOME</b> <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Centreville</b>			21f. LOCATION STREET <b>Centreville Dr</b>		CITY OR TOWN <b>Centreville</b>		COUNTY <b>Md.</b>		
		22a. I certify that (I) (this hospital) attended the deceased from <b>May 23 1986</b> to <b>May 27 1986</b> , that (I) (we) last saw the deceased alive on <b>May 23 1986</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. DEGREE <b>John Jones Jr</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>5/28/86</b>					
		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>J.R. Smith Jr.</b>		22e. ADDRESS <b>Centreville Dr</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/28/86</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Chester Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Chestertown, Md.</b>		23e. COUNTY <b>Md.</b>				
24. FUNERAL DIRECTOR NAME <b>G. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 28 1986</b>		25b. REGISTRAR'S SIGNATURE <b>Julie Davidson-Pender</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use at the burial or cremation. If page 3 is removed, attach it to the death certificate.

IMPORTANT: If item 21 is marked or item 16b. shows an injury, or other traumatic event, the indicated conditions may be omitted.

10760-0

10760

copy

00-07577

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

8 6 1 5 3 8 0

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME      FIRST      MIDDLE      LAST				2a DATE OF DEATH      MONTH      DAY      YEAR				2b HOUR	
Lula States Meekins				May 24, 1986				5:45 P.M.	
3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		white		Feb 1, 1916		70 YRS			
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Kent Co. Md.		USA				Queen Anne Co.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY			
Centreville		Corsica Hills Nursing Center		Housewife					
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE RFD Broad Neck 21620	
Md.		Kent		Chestertown					
14 FATHER'S NAME FIRST      MIDDLE      LAST		15 MOTHER'S MAIDEN NAME FIRST      MIDDLE      LAST							
George W. States		Lula Kirby							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS			
No		218 70 3643		Deceased while living					
18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Circulatory Collapse</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several minutes</i>									
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Long standing Diabetes Mellitus many years</i>									
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>8/17</u> , 19 <u>81</u> , to <u>5/24</u> , 19 <u>86</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <i>Gottfried Baumann</i> DEGREE <i>MD</i>									
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS						22f DATE SIGNED <i>5/25/86</i>	
C. Gottfried Baumann		Chestertown, Md. 21620							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 5/27/1986		23c NAME OF CEMETERY OR CREMATORIUM Chester Cemetery		23d LOCATION CITY OR TOWN Chestertown, Md.		STATE	
24 FUNERAL DIRECTOR NAME <i>J. Willis Wells</i>		25a DATE REC'D. BY REGISTRAR MAY 28 1986		25b REGISTRAR'S SIGNATURE <i>Julia Davidson</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached from use as the burial permit. Then please remove pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene, printer No burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

77251-00



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deceased be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the funeral director and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Transit Permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation or other disposition.

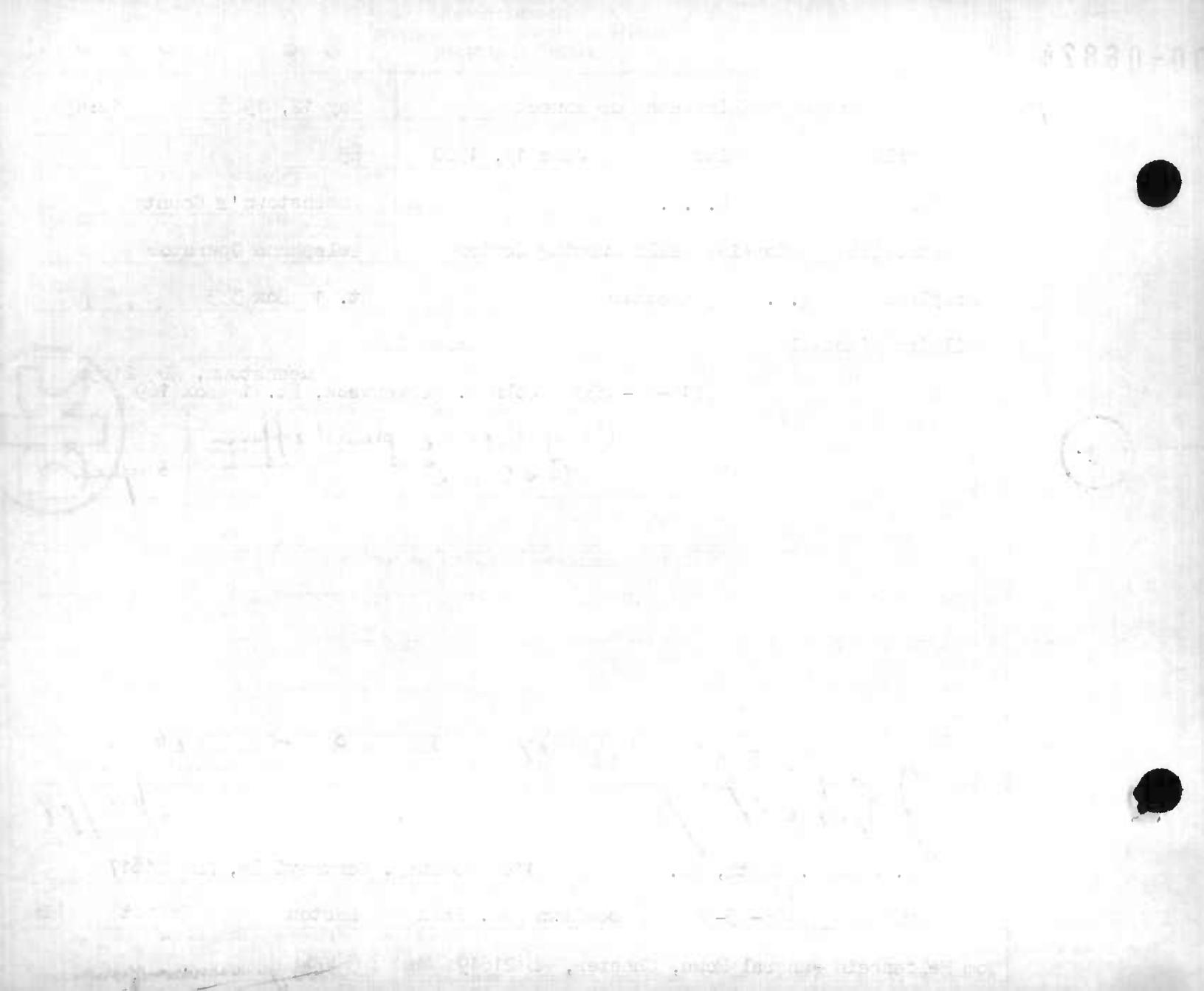
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified by one:

### MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8615381		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
<i>Katheryn Elizabeth Morgenweck</i>						May 12, 1986						10:45P M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		June 19, 1900			85			YEARS	MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.					Queen Anne's County			MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Centreville		Corsica Hills Nursing Center					Telephone Operator							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			Rt. 1 Box 333 21619					
Maryland	Q.A.	Chester												
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST						
William Mitchell				Sarah Cole										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			John R. Morgenweck, Rt. 1 Box 169 Queenstown, MD 21658							
No		213-10-3333												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1		
DUE TO, OR AS A CONSEQUENCE OF <i>Ca 7 Colon &amp; pleural effusion</i> as CVD												5 years		
DUE TO, OR AS A CONSEQUENCE OF (b) _____														
DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 5-8 4-24 1986 to 5-11 1986 that (I) (we) last saw the deceased alive on 5-8 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.														
22b. SIGNATURE <i>J. R. Smith, Jr.</i> DEGREE														
22d. PHYSICIAN'S NAME (THE OFFICE/HOME)		22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED <i>5/14/86</i>						
Dr. John R. Smith, MD.		110 Broadway, Centreville, MD 21617												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY			23f. STATE		
Burial		05-15-86		Woodlawn Mem. Park			Easton		Talbot			MD		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Tom Helfenbein Funeral Home, Chester, MD 21619					MAY 16 1986									

00-06824  
BP\_\_\_\_\_  
DHMH - 16 60M 7/84  
(VRA 15, 4)

43830-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the Burial and Transit Permit. Then please remove carbon copy of page 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8015382			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2d HOUR						
Mildred Virginia Motichka						May 27, 1986			12:45 A.M.						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR					
Female		White		October 13, 1934			51 YRS.			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Pennsylvania		USA						Queen Anne's							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			residence,			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Centreville		204 Tilghman Ave.						Wife			Home				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE						
Maryland		QueenAnne's		Centreville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			204 Tilghman Ave., 21617						
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			LAST						
Andrew		---		Madar		Agnes			Nedelak						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Husband Bernard W. Motichka, Centreville, Md. 21617			ADDRESS 204 Tilghman Ave.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		202-26-0891									hour				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Brain tumor DUE TO, OR AS A CONSEQUENCE OF (c)														2½ year	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION Sept 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -Nov 19, 84 - Nov 13, 85 (Brain tumor)			19c. AUTOPSY? <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5/13/86			21f. LOCATION STREET 5/27/86			CITY OR TOWN 5/27/86			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 5/13/86 to 5/27/86, that (I) (did not) view the body after death, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.															
22b. SIGNATURE Willard F. Smith MD		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 5/27/86							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Willard F. Smith		22f. ADDRESS Route 301, Queenstown, Md. 21617													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE May 29, 1986			23c. NAME OF CEMETERY OR CREMATORIUM St. Peter's Cemetery			23d. LOCATION CITY OR TOWN Queenstown, Q.A. Co., Md.			COUNTY STATE				
24 FUNERAL DIRECTOR NAME James H. Barton, Jr., Centreville, Md. 21617		25. DATE RECEIVED BY FUNERAL DIRECTOR JUN 02 1986 John Barton Jr.													
DHMH - 16 50M 4/B3 (VRA 15, 4)															

192

activities slightly increased

and began to

slowly

decreased.

Afternoon

had been

and

the

activities

of the day were

beginning to

193 , 194, 195, 196

businesses closing

business

—

slowly

zabot

—

women

197, 198, 199

men

199

c.

199, 200, 201, 202, 203

conversations between men

199-200

c.

200, 201, 202, 203, 204

200-201

c.

201, 202, 203, 204, 205

201-202

c.

202, 203, 204, 205, 206

202-203

c.

203, 204, 205, 206, 207

203-204

c.

204, 205, 206, 207, 208

204-205

c.

205, 206, 207, 208, 209

205-206

c.

206, 207, 208, 209, 210

206-207

c.

207, 208, 209, 210, 211

207-208

c.

208, 209, 210, 211, 212

208-209

c.

209, 210, 211, 212, 213

209-210

c.

210, 211, 212, 213, 214

210-211

c.

211, 212, 213, 214, 215

211-212

c.

212, 213, 214, 215, 216

212-213

c.

213, 214, 215, 216, 217

213-214

c.

214, 215, 216, 217, 218

214-215

c.

215, 216, 217, 218, 219

215-216

c.

216, 217, 218, 219, 220

216-217

c.

217, 218, 219, 220, 221

217-218

c.

218, 219, 220, 221, 222

218-219

c.

219, 220, 221, 222, 223

219-220

c.

220, 221, 222, 223, 224

220-221

c.

221, 222, 223, 224, 225

221-222

c.

222, 223, 224, 225, 226

222-223

c.

223, 224, 225, 226, 227

223-224

c.

224, 225, 226, 227, 228

224-225

c.

225, 226, 227, 228, 229

225-226

c.

226, 227, 228, 229, 230

226-227

c.

227, 228, 229, 230, 231

227-228

c.

228, 229, 230, 231, 232

228-229

c.

229, 230, 231, 232, 233

229-230

c.

230, 231, 232, 233, 234

230-231

c.

231, 232, 233, 234, 235

231-232

c.

232, 233, 234, 235, 236

232-233

c.

233, 234, 235, 236, 237

233-234

c.

234, 235, 236, 237, 238

234-235

c.

235, 236, 237, 238, 239

235-236

c.

236, 237, 238, 239, 240

236-237

c.

237, 238, 239, 240, 241

237-238

c.

238, 239, 240, 241, 242

238-239

c.

239, 240, 241, 242, 243

239-240

c.

240, 241, 242, 243, 244

240-241

c.

241, 242, 243, 244, 245

241-242

c.

242, 243, 244, 245, 246

242-243

c.

243, 244, 245, 246, 247

243-244

c.

244, 245, 246, 247, 248

244-245

c.

245, 246, 247, 248, 249

245-246

c.

246, 247, 248, 249, 250

246-247

c.

247, 248, 249, 250, 251

247-248

c.

248, 249, 250, 251, 252

248-249

c.

249, 250, 251, 252, 253

249-250

c.

250, 251, 252, 253, 254

250-251

c.

251, 252, 253, 254, 255

251-252

c.

252, 253, 254, 255, 256

252-253

c.

253, 254, 255, 256, 257

253-254

c.

254, 255, 256, 257, 258

254-255

c.

255, 256, 257, 258, 259

255-256

c.

256, 257, 258, 259, 260

256-257

c.

257, 258, 259, 260, 261

257-258

c.

258, 259, 260, 261, 262

258-259

c.

259, 260, 261, 262, 263

259-260

c.

260, 261, 262, 263, 264

260-261

c.

261, 262, 263, 264, 265

261-262

c.

262, 263, 264, 265, 266

262-263

c.

263, 264, 265, 266, 267

263-264

c.

264, 265, 266, 267, 268

264-265

c.

265, 266, 267, 268, 269

265-266

c.

266, 267, 268, 269, 270

266-267

c.

267, 268, 269, 270, 271

267-268

c.

268, 269, 270, 271, 272

268-269

c.

269, 270, 271, 272, 273

269-270

c.

270, 271, 272, 273, 274

270-271

c.

271, 272, 273, 274, 275

271-272

c.

272, 273, 274, 275, 276

272-273

c.

273, 274, 275, 276, 277

273-274

c.

274, 275, 276, 277, 278

274-275

c.

275, 276, 277, 278, 279

275-276

c.

276, 277, 278, 279, 280

276-277

c.

277, 278, 279, 280, 281

277-278

c.

278, 279, 280, 281, 282

278-279

c.

279, 280, 281, 282, 283

279-280

c.

280, 281, 282, 283, 284

280-281

c.

281, 282, 283, 284, 285

281-282

c.

282, 283, 284, 285, 286

282-283

c.

283, 284, 285, 286, 287

283-284

c.

284, 285, 286, 287, 288

284-285

c.

285, 286, 287, 288, 289

285-286

00-08469

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

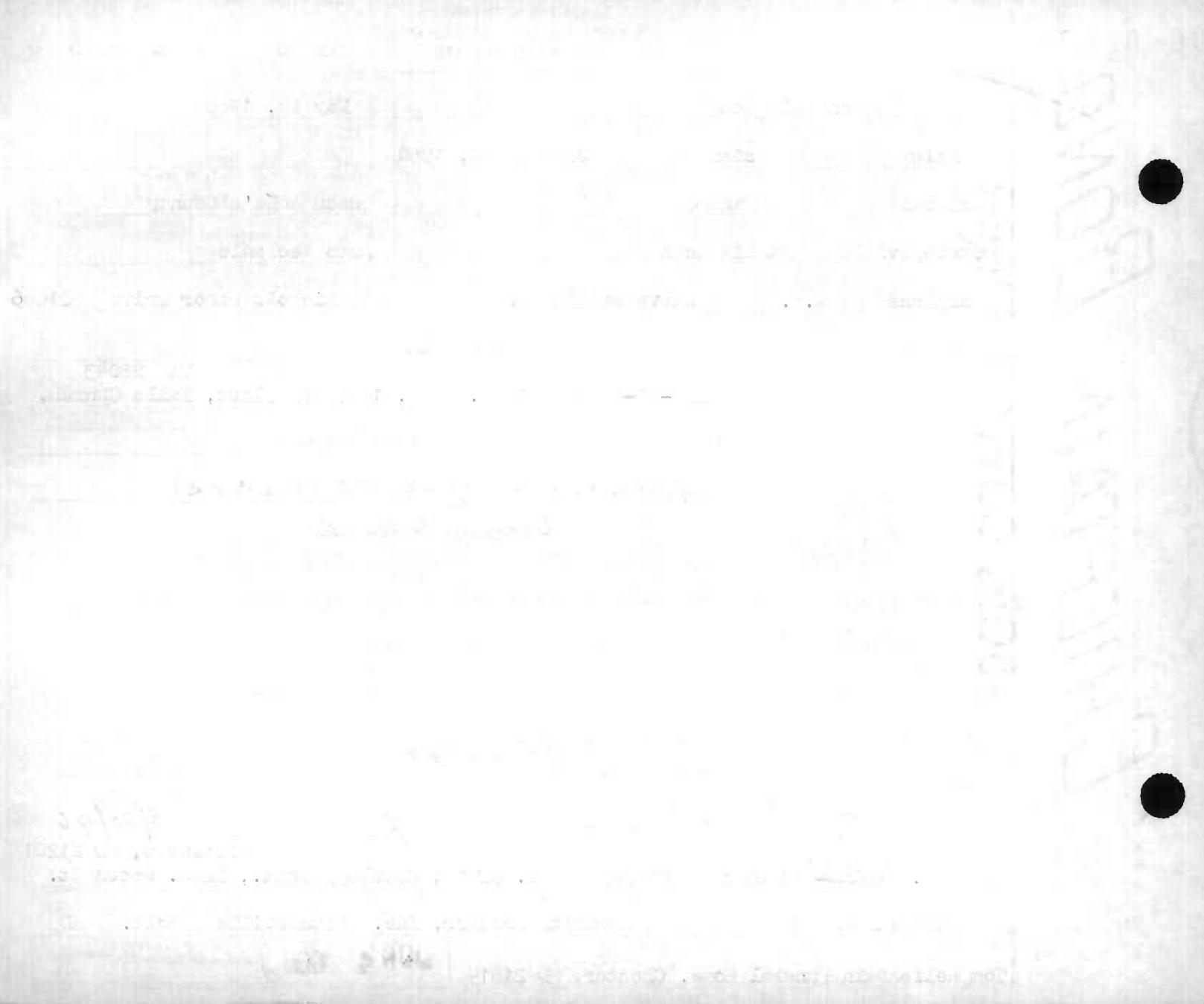
## MEDICAL CERTIFICATION

1 - STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 15383

1. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
Heng Kim Seng			May 28, 1986			M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		Asian		January 10, 1950		36	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Cambodia		Refugee				Queen Anne's County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Stevensville		At his home		Auto Mechanic			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE	13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
Maryland	Q.A.	Stevensville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		219 Nichols Manor Drive 21665	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Sin Uth		Seng Sim					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		223-23-0262		Kim H. Seng, 1947 Fay Place, Falls Church,		VA 22043	
18. CAUSE OF DEATH (Enter only one cause per line for 18, (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic and Renal failure</u>							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HEPATOMA (CANCER OF LIVER)</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Lung metastases</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3-7-</u> , 19 <u>86</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>5-2-</u> , 19 <u>86</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Mrs. A. Didolkar</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>5/30/86</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MUKUND Dr. Gurton Didolkar</u>		22e. ADDRESS		Baltimore, MD 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Security Process, Inc.		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balt. MD	
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Chester, MD 21619		ADDRESS		25a. DATE REC'D. BY REGISTRAR JUN 4 1986		25b. REGISTRAR'S SIGNATURE <u>Jude Davidson</u>	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PEN IN LINE 11B. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 5384								
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN X OF ESTI- MATED			MONTH DAY YEAR		2d. HOUR						
			James P. Stranic						<input checked="" type="checkbox"/> 5-16-86			19								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS) LAST BIRTHDAY			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR		2d. HOUR		
Male		White		12 23 52			33 yrs.							5-16-86 19		2:10 PM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.									
Ill.		U.S.A.			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Queen Anne's County												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Queens town			Rt. 301&18			Moving V.P.			Moving											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
N.J.		Burlington		Marlton			<input checked="" type="checkbox"/> YES			4 Dorset Dr. 08053			99999							
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
William J. Stranic			Irma Nelson			190 44 6444			McChesney Funeral Home											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)			19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1PM 5-16-86 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver of a vehicle in collision with another vehicle			21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Rt. 301&18			21e. STATE Queen Anne's County, Md.								
21f. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21g. TITLE (SPECIFY) M.D. Assistant			21h. MEDICAL EXAMINER			21i. DATE SIGNED 5-17-86											
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			22b. ACTUAL SIGNATURE <i>Margarita A. Korell</i>			22c. EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			22d. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 5-18-86			23c. NAME OF CEMETERY OR CREMATORIAL Ferris Crematory			23d. LOCATION CITY OR TOWN West Chester Pa.											
24. FUNERAL DIRECTOR NAME Gary L. Kaufman Funeral Home			25a. DATE REC'D. BY REGISTRAR MAY 19 1986			25b. REGISTRAR'S SIGNATURE <i>Julie Luskson-Parker</i>														
5695 Main St. Elkhridge, Maryland 21227																				
DHM-17 BP (VR A15 ME (5))																				

Digitized by srujanika@gmail.com



• 2020-07-01

~~RECORDED~~ DATED

1980-1981

وَمِنْهُمْ مَنْ يَرْجُوا أَنْ يُخْلَدُوا فِي الْأَرْضِ  
وَمِنْهُمْ مَنْ يَرْجُوا أَنْ يُخْلَدُوا فِي الْأَنْهَارِ